

DISCUSSION PAPER: FACILITY BYPASS

Within this trauma system manual there are guidelines for decision criteria that can be used by Regional Advisory Councils (RACs) when developing bypass protocols for regional trauma systems. However, the RACs should remember that these guidelines are generic in posture and there are many factors which come into play when developing trauma system protocols. Following are considerations that should be factored in prior to promulgating bypass guidelines or protocols.

The capabilities of prehospital personnel vary greatly from one EMS provider to another. This is particularly true in rural areas where a service which usually offers basic life support can be capable of offering advanced life support on nights or weekends when the appropriate staff may be available. On the other end of the continuum may be a service which has a personnel variance and may have only one certified ECA on board. Additionally, there may be other considerations if the EMS provider is a volunteer service. If the provider is instructed to bypass the nearest facility, it may tie up the only available unit in that community for a number of hours. It may be more propitious in some instances to stop for stabilization and consider transfer services, if available, for continuation to a tertiary care facility.

The number of potential Comprehensive trauma facilities in the state is minimal. For a while there may be only a few regional trauma systems (RTS) in which there is a Major facility. The majority of RTSs will have only General trauma facilities within their boundaries. In most cases, one of these General facilities will need to take on the role of lead trauma facility. The majority of severe and major trauma victims will stay within this facility and only in rare cases can one of these victims be expected to be transported out to a comprehensive or major facility within another RTS.

Some small hospitals have moderately sophisticated stabilization resources. Others have only an "emergency room" where neither the personnel nor equipment is prepared to handle major trauma, even through the stabilization phase. However, as is the case with prehospital providers, the situation in these facilities can present a completely different picture when resident emergency physicians moonlight in these hospitals on nights or weekends. RACs should have privy to these individual idiosyncrasies when discussing bypass.

Any consideration of triage or bypass decision schemes should allow for the possibility of over-triage. Studies indicate that for all major trauma patients there is a 35-40% over-triage. This is considered necessary in order to assure that all patients reach appropriate care. This consideration should be discussed in depth at the regional level in order to alleviate misunderstandings that may develop. If over-triage is not factored in, there is a possibility that prehospital providers may get caught in the middle of unpleasanties.

Since Texas legislation has indicated that there can be no arbitrary limit set on the number of trauma facilities within a given trauma system, there is a possibility that there will be more than one facility capable of taking "the lead" within any given area. In these instances, RACs will need to negotiate and define responsibilities clearly and factor these into any by-pass plans.

TRAUMA

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